STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey and a complaint investigation conducted in your facility from 6/9/09 to 7/29/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was four. Four resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D. Complaints NV00022228 and NV00022544 were substantiated, see Tags Y85 and Y812.	Y 000		
Y 026 SS=C	449.190(3) Contents of License-Multiple Types NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. This Regulation is not met as evidenced by:	Y 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 026	Continued From page 1 Based on observation, record review and interview on 6/9/09, the facility was caring for 1 of 1 persons with a mental illnesse without an endorsement (Resident #1). See also Tags Y812 and Y1010. Severity: 1 Scope: 3	Y 026		
Y 072 SS=F	449.196(3) Qualications of Caregiver-Med Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 6/9/09 and 6/26/09, the facility failed to ensure the files for 2 of 4 caregivers contained a copy of a certificate for initial medication administration training and passing the examination. The two employees had evidence of attending and passing an	Y 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 072	Continued From page 2 examination for refresher training only (Employee #2 - refresher training on 12/16/06; Employee #4 - refresher training on 6/28/08). Severity: 1 Scope: 2	Y 072		
Y 085 SS=F	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. This Regulation is not met as evidenced by: Based on observation and interview of 6/24/09, the facility operator failed to ensure a caregiver was on the premises at all times one or more residents is present. Three residents were present in the facility with the owner's mother while the owner and caregivers were attending a training. The owner's mother reported she was not a caregiver (Resident #1, #2 and #4). Severity: 2 Scope: 3	Y 085		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each	Y 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 3 member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Based on record review on 6/26/09, the facility failed to ensure 1 of 5 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #5 was hired in June 2009 with a negative one-step TB test completed on 1/30/09. He had a physical and a chest x-ray on 2/17/09 but there was no evidence of a second step TB test). This was a repeat deficiency from the 1/15/09 State Licensure survey. Severity: 2 Scope: 3	Y 103		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 6/9/09 and 6/26/09, the facility failed to ensure 3 of 5 employees met background check requirements (Employee #1 did not have a copy of a FBI background check in the file; Employee #4 was hired in June 2009, the	Y 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 105	Continued From page 4 fingerprints in the file were dated 6/9/08 and there was no evidence of background checks from the State or FBI completed within the last six months; Employee #5 had no evidence of an FBI background check in his file). Severity: 2 Scope: 3	Y 105		
Y 172 SS=D	449.209(2) Health and Sanitation-Outside garbage NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. This Regulation is not met as evidenced by: Based on observation on 6/9/09, the facility did not ensure all outside garbage containers were provided with a lid and kept reasonably clean. Severity: 2 Scope: 1	Y 172		
Y 320 SS=D	449.220(1) Bedroom Doors - Locks NAC 449.220 1. A bedroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge.	Y 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 320	Continued From page 5 This Regulation is not met as evidenced by: Based on observation on 6/9/09, the facility failed to ensure 1 of 5 bedroom door locks could be opened with a single motion. (Bedroom #5) Severity: 2 Scope: 1	Y 320		
Y 435 SS=C	449.229(4) Fire Extinguisher; Inspection NAC 449.229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshall to conduct such inspections. This Regulation is not met as evidenced by: Based on observation on 6/9/09, the facility failed to ensure the facility fire extinguishers were inspected annually. The charge indicator on the fire extinguishers showed they were charged but they were last inspected on 5/7/08. Severity: 1 Scope: 3	Y 435		
Y 812 SS=I	449.2732(1)(c) Protective Supervision NAC 449.2732 1. Except as otherwise provided in subsection 2, a person who requires protective supervision may not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (c) The resident can be protected from harming himself and other persons.	Y 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 812	Continued From page 6	Y 812		

This Regulation is not met as evidenced by:
Based on observation, record review and interview on 6/9/09 to 7/29/09, the facility failed to provide adequate protective supervision for a resident with mental illness (Resident #1) to prevent the resident from harming 4 of 4 residents in the facility (Resident #1, #2, #4 and #5).

Findings include:

On arrival to the facility on 6/9/09 at 9:05 AM, an older Asian male met the survey team at the front door and reported the owner was not in the home. He stated a resident left the facility on her own in a wheelchair and the owner followed the resident down the street to try to bring her back. He related that the resident was hitting the owner as she tried to wheel the resident back to the house and the police had been called by a neighbor.

This surveyor walked in the direction indicated by the Asian male, rounded the corner and saw Resident #1 midway down the block with the owner, her boyfriend and a male resident. The owner was trying to talk to the resident but the resident was talking over her about multiple topics including communism, the Chinese, about not trusting anyone, that the person using her name was dead and she was not that person. A police unit arrived and took over the situation. The police officer asked the owner for a contact number for the resident's social worker (SW); the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 812	Continued From page 7 owner and I returned to the facility to call the SW. Resident #1's SW informed the police the resident was a guardian of the State and she was not allowed to leave the facility on her own. The SW questioned the owner about the resident's medications and the owner reported the resident received her morning medications. The SW tried to talk to the resident over the phone but the resident talked over the SW and refused to listen to her. The SW gave the police permission to transfer Resident #1 to Renown Hospital with a referral to Northern Nevada Mental Health for an evaluation of the resident's medications. Review of Resident #1's record revealed the resident moved to this facility on 4/30/09 from another adult group care facility that did not have a mental illness endorsement. The owner reported she has a license endorsement for mental retardation and she thought she could take residents with mental illness. The resident has diagnoses of schizoaffective disorder, bipolar disorder, and borderline personality disorder. Her medications include Zyprexa (an antipsychotic), Lisinopril (for high blood pressure), Omeprazole (for heartburn) and Trileptal (for seizures). The owner was informed she would have to apply for a Mental Illness endorsement and have her caregivers attend mental illness training before she could accept residents with mental illnesses. During visits to the facility on 6/24/09 and 6/26/09, Resident #1 was observed sitting and smoking on the front porch of the facility. The resident was talking aloud to no one in particular but was not speaking or acting aggressively toward staff or other residents. On 6/26/09, the owner reported she has applied for a mental illness endorsement with the Bureau, and she	Y 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 812	Continued From page 8 and her staff attended Mental Illness training on 6/24/09. On Monday 7/13/09 at 7:55 AM, the facility owner called the Bureau to request the phone number for the social worker for Resident #1. The owner reported there was a fire during the night at the facility and she was at a motel with Residents #4 and #5 and her family. The owner related that Resident #1 came to her bedroom at 1:30 AM asking for a cigarette and she told the resident it was too early for a cigarette and to go back to bed. The owner stated that a short while later, around 2:00 AM, she was woken by the fire alarm and there was smoke in the house. She stated that she got the residents and her family out of the house and that the fire department and police responded to the fire alarm. The owner reported it was discovered Resident #1 set her mattress on fire. Resident #1 told the police that she had started the fire and they arrested her. Resident #3 was transported to the hospital due to shortness of breath and was later released. The owner reported the American Red Cross placed her family and the residents in a Travel Lodge motel for Sunday and Monday nights and they expected to return to the facility on Tuesday. A visit was made to the house at 5:00 PM on Monday, 7/13/09. There was no external damage noticeable from the front of house though the sides and back of the house were not accessible. There was a mattress with a burnt area laying in the front driveway. A second visit was made on Thursday, 7/16/09, and there was no one in the facility. A neighbor reported the owner had been in the home earlier in the day and was removing smoke damaged items from the home. The neighbor said the owner told her they were be moving back into the home on Friday. The	Y 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 812	Continued From page 9 neighbor related that home smelled like smoke and the owner said they would have to have to refurbish the house and repair the fire damaged room. An onsite visit was made on Wednesday, 7/29/09. The operator reported she and the residents remained in the hotel until Friday, 7/17/09, to allow for the fire system to be reset and damaged items removed from the home. The room where the fire originated was having the walls replaced and all the carpeting in the facility had been removed. The hardwood floors were being repaired and the other walls of the facility were being repainted. The owner was questioned about how Resident #1 started the fire. The owner stated the resident had access to a cigarette lighter. The owner reported she found out Resident #1 warned the resident in the room next to hers that she was going to start the fire and that he should get out of the house. The owner stated the social worker for Resident #1 called to ask if the resident could be returned to the home and the owner told the social worker she would not accept Resident #1 back into the facility. Severity: 3 Scope: 3	Y 812		
Y 878 SS=G	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 10 administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on interviews and record reviews on 6/9/09, the facility did not ensure 1 of 4 residents received a medication as ordered by a physician. (Resident #2) Findings include: Resident #2 was admitted to the facility on 11/20/08 with diagnoses of a Vitamin B12 deficiency and dementia. The resident was prescribed Cyanocobalam 1000 micrograms per milliliter (mcg/ml), 1 ml to be injected intramuscularly every month. The resident's medication basket contained three vials of this medication: a 10 ml vial for 10 doses filled on 12/12/08 that was 3/4 full, two - 1 ml vials containing one dose each that were filled on 1/24/09 and 4/15/09 - both vials were full and had not been opened. Resident #2's medication administration records (MAR) for June, May, April and March 2009 listed the Vitamin B12 but there were no initials showing the medication had been given. The owner reported the medication was not given to the resident by the caregivers. She stated the resident's physician injected the resident with the medication when he visited the resident at the facility.	Y 878		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 11 Review of Resident #2's physician visit reports revealed the doctor came to the facility on 1/15/09 and 4/19/09. The 4/19/09 report indicated the physician would do a follow up visit in three months. There was no evidence the resident saw his physician or received the Vitamin B12 shots in February, March, May or June of 2009. Resident #2 was interviewed in his room on 6/6/09. The resident was able to related that he was not giving himself the shots. He could not remember the last time he got a Vitamin B12 shot but thought he was getting them every month from his doctor. Severity: 3 Scope: 1	Y 878		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 6/9/09, the facility failed to ensure 1 of 4 residents complied with NAC 441A.380 regarding tuberculosis (TB) testing (Resident #1 was admitted on 4/30/09	Y 936		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2010AGC	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAULS HOME CARE	1500 MANHATTAN ST RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 12 with a two step TB test completed on 10/11/08. The facility did not complete a TB signs and symptoms surveillance) which affected all residents. This was a repeat deficiency from the 1/15/09 State Licensure survey. Severity: 2 Scope: 3	Y 936		
Y1010 SS=F	449.2764(1) MI Training NAC 449.2764 1. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after he becomes employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. This Regulation is not met as evidenced by: Based on record review and interview on 6/9/09, the facility failed to ensure 2 of 2 caregivers employed at the facility for more than 60 had at least 8 hours of training in the care of persons with mental illness prior to accepting a mentally ill resident (Employee #1 and #2). See also Tag Y026 Severity: 2 Scope: 3	Y1010		